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The American Atlas of Stereoroentgenology

A QUARTERLY

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of

Stereoroentgenology

A QUARTERLY

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EDITORS:

LEOPOLD JACHES, M. D.   WILLIAM H. STEWART, M. D.   H. M. IMBODEN, M. D.

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THE CAUSE OF THE ROENTGEN SHADOW IN CASES OF SUBACROMIAL (SUBDELTOID) BURSITIS

By WALTER M. BRICKNER, M. D., F. A. C. S.
Associate Surgeon, Mount Sinai Hospital, New York

ROENTGENOGRAPHISTS have commonly regarded, and reported, the shadow often found in the neighborhood of the greater tuberosity and head of the humerus in cases of subacromial (subdeltoid) bursitis as due to "thickening of the bursa," or to "calcareous deposit in the bursa." (Holzknecht even went so far as to attribute it to a "bursalith.") These interpretations arose partly from the fact that the shadow often appears to occupy the situation and follow the line of the bursa, and partly to faulty observations by surgeons who have reported operations, here and there, in these cases.

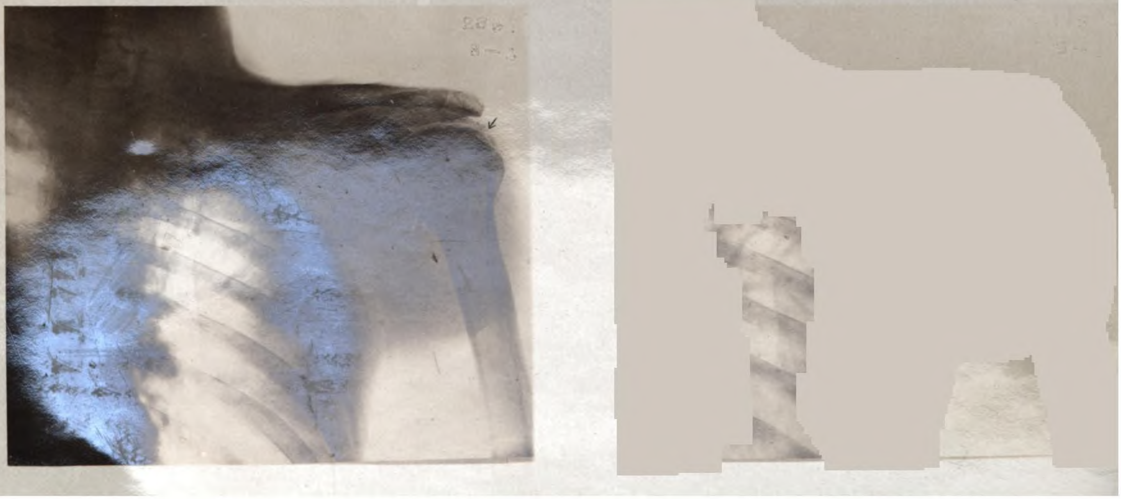
¶ The shadow is **not** due to thickening of the bursa. It is due to lime salt deposit; but this deposit, which may be multiple, is not in but **beneath the bursa,** in or upon, or in and upon the supraspinatus tendon, or occasionally the infraspinatus near its insertion into the greater tuberosity.

The bursa itself casts no shadow, although it may show thickening and adhesions of its walls and more or less (usually little) serous effusion. These observations are based upon the findings in, to date, fifteen operations. (The lesions in the tendon and the bursa, and the character and distribution of the deposits I have described in the *American Journal of the Medical Sciences,* March, 1915, and the *Interstate Medical Journal,* April, 1915.)

¶ The deposit may be very small—scarcely larger than a pinhead—or quite large, even forming a cap over the outer portion of the head of the humerus; it may be located, and most often is, near the greater tuberosity, or more internally where its shadow may be covered and obscured by that of

Showing a Calcareous Deposit Beneath the Subacromial Bursa

Stereo. 11. **Serial №** **405**



the acromion process, or singly, or in multiple, between these points, or extending in the line of the bursa.

¶ The roentgenogram should be reported by the roentgenographist as "showing a calcareous deposit (or deposits) beneath the subacromial bursa."

¶ A lime salt deposit close to the greater tuberosity and a small fracture of the tuberosity itself closely resemble each other, both clinically and roentgenographically. They can be distinguished by noting carefully the outline of the tuberosity (if necessary, comparing with a roentgenogram of the opposite shoulder) and by observing whether or not the shadow shows bone structure.

STEREOROENTGENOGRAMS OF THE ANTERIOR THORACIC WALL, WITH THE HEART IN SITU

By Leon Theodore Le Wald, M. D. and H. D. Senior, M. D.

[From the Edward N. Gibbs Memorial X-Ray Laboratory, and the Department of Anatomy, University and Bellevue Hospital Medical College, New York University.]

THE stereoroentgenogram, teleroentgenogram, and explanatory outline drawing here reproduced represent the heart and its valvular orifices in their relation to the anterior thoracic wall.

¶ The subject was a woman, who died at forty, of acute pneumonia (without effusion) of the right upper and middle lobes. There was a single small focus of healed tubercle in the left apex, otherwise the organs were normal.

¶ The body was injected through the right cartoid artery with equal parts of commercial formalin and water; the injection being begun with the body in the horizontal and finished in the vertical position. The body, which had been stored in the horizontal position for some months, was frozen and the thorax removed. The frozen thorax was then cut, by means of a band saw, accurately in the frontal plane so as to open both auricles from behind, without interfering with the contour of the heart. In the intact anterior portion of the thorax the mitral and tricuspid valves were readily accessible. Wires were bent to accu-

rately fit the groove corresponding to the attachment of the valves to the heart wall. The wires were placed in position from the auricle and, in the case of the tricuspid valve, fixed by means of two sutures. The cusps of both auriculo-ventricular valves were found to be in apposition. The interior of the aorta was reached through the anterior wall of the left auricle. The region of the pulmonary valve was made accessible by removing the remainder of the left lung and cutting the artery longitudinally from the left side. Wires were shaped to fit the aortic and pulmonary orifices and placed so that they were in contact with the deepest part of each of the semilunar valve cusps, which provided excellent guides in placing the wires. After placing the pulmonary ring, the cut edges of the vessel came into position spontaneously. The accuracy of the position of the wires was verified after reproduction.

¶ The first teleroentgenographs were taken with the material frozen, the remaining portions of the lungs and liver having been removed after freezing. The parts were so rigid, however, that after the first trials freezing was not repeated. It can safely be said, that lack of rigidity is not a source of error. To minimize optical distortion the tube was placed six feet from the object, which was horizontal, with the anterior surface in contact with the plate holder. The tube was accurately centered on a shot, which may be distinguished in the cut a short distance above the tricuspid ring. The shot is imbedded in the skin of the median line of the thorax at the middle of the longitudinal area occupied by the wires. (Fig. 1.)

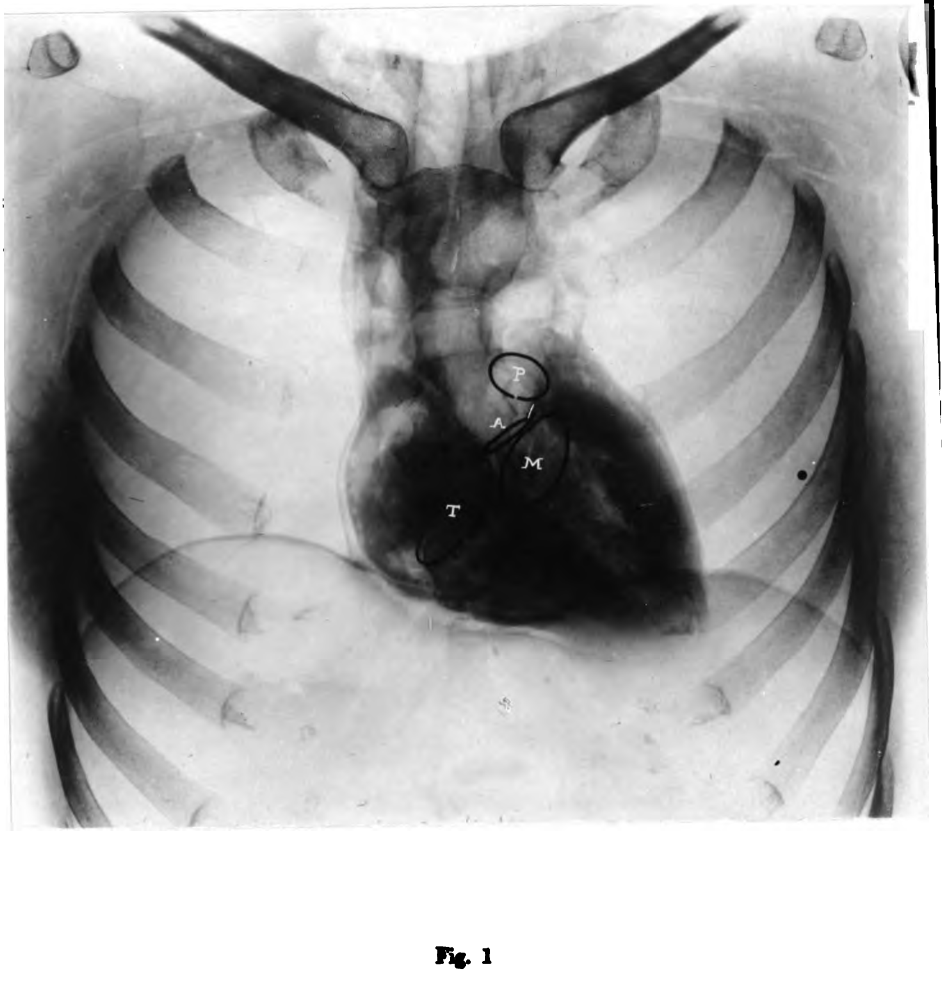


Fig. 1

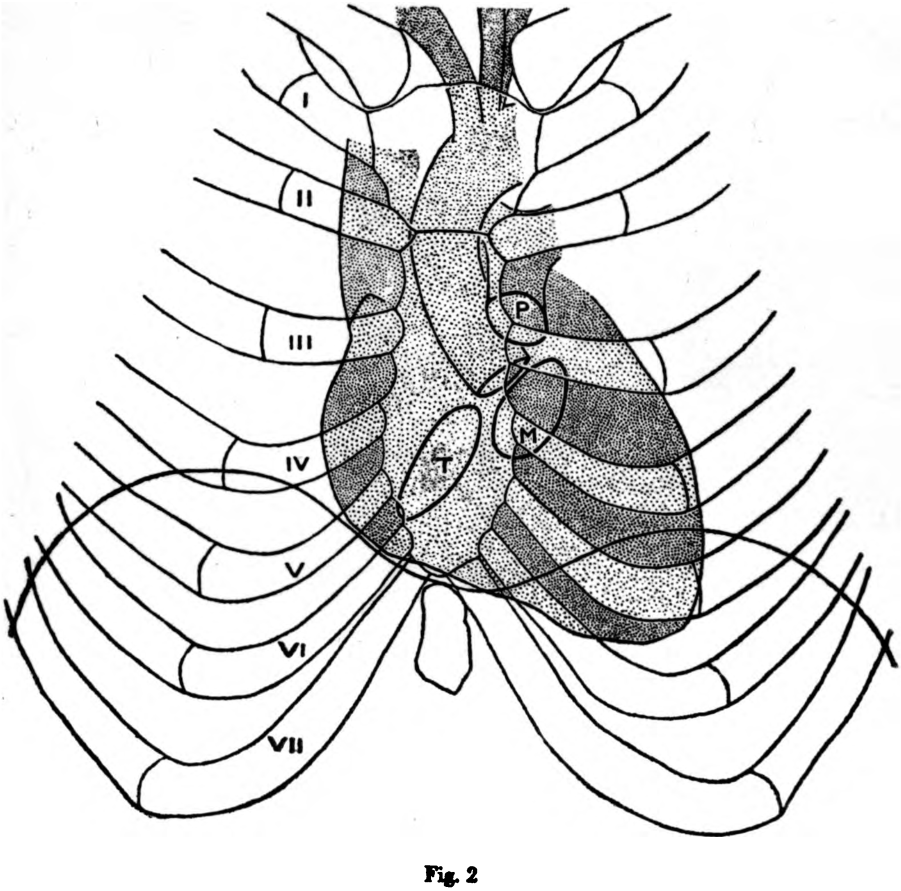


Fig. 2

¶ Stereoroentgenograms were made in the usual way and the subject was also Roentgenographed in various positions.

¶ The outline drawing was traced from the negative, most of the doubtful points in which were elucidated by the stereoscope. The left limit of the superior vena cava, and a small portion of the upper left margin of the heart, where the latter is confused by the root of the lung, could not be determined with certainty. The outline is omitted from these regions, but subsequent removal of the heart testifies to the approximate accuracy of the dotted lines by which these margins are indicated. Several parts identified in the stereoscopic picture have been omitted for the sake of clearness, such, for instance, as the inferior vena cava, and the anterior papillary muscles of the right and left ventricles, and one of the mitral cusps.

¶ The **apex** is in the fifth intercostal space, 7.5 to 8 cm. (3 to 3¼ in.) from the median line. The **base** (above) corresponds to an imaginary line (A) drawn from a point 1 cm. (⅖ in.) below the second left chrondro-sternal articulation, and 3 cm. (1⅕ in.) from the median line, to another point (the same distance from the median line) 1 cm. above the right third chondro-sternal articulation. The **margo acutus,** or lower border corresponds to a line (B) drawn from the apex through the xiphi-sternal articulation, to a point on the sixth costal cartilage 2 cm. to the right of the median line. The **right border** of the heart may be indicated approximately by an imaginary line (slightly convex to the right) joining the right ends of (A) and (B). The **left border** corresponds to a line (slightly convex to the left) joining the left end of (A) to the apex.

¶ If a line be drawn from the upper margin of the left third chondro-sternal articulation to the right edge of the sternum in the fifth intercostal space, the upper end of the line will lie over the centre of the pulmonary orifice, and the lower two-thirds of it (approximately) will overlie the main axis of the tricuspid orifice. The aortic orifice is immediately to the left of the above line, with its centre at the left edge of the sternum, opposite the third space. The mitral orifice is very largely behind the third left interspace; its upper end is behind the third cartilage, its lower behind the left margin of the sternum opposite the fourth cartilage and space.

¶ Of the orifices of the heart, the pulmonary is nearest the anterior thoracic wall, the tricuspid is slightly in advance of the aortic, and the mitral is deepest of all.

¶ The pericardium follows the heart closely. The upper end (apex) in this subject, extended up, behind the sternum, to the lower margin of the first costal cartilage on the right and the upper margin of the second on the left.

¶ The positions occupied by the cardiac orifices are so plainly to be seen that it is unnecessary to describe them further; it may be said, however, that all the rings are seen from the lower (anterior) aspect except the aortic, which is seen from above.

¶ The paper by Norris and Fetterolf,[1] which appeared shortly after our first experiments, and that by Groedel,[2] will be found of value to those interested in the subject of cardiac topography as studied by means of the X-ray. Groedel writes as follows:

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[1] American Journal Med. Sciences, Feb. 1913.

[2] Archives of the Roentgen Ray, Aug. 1912.

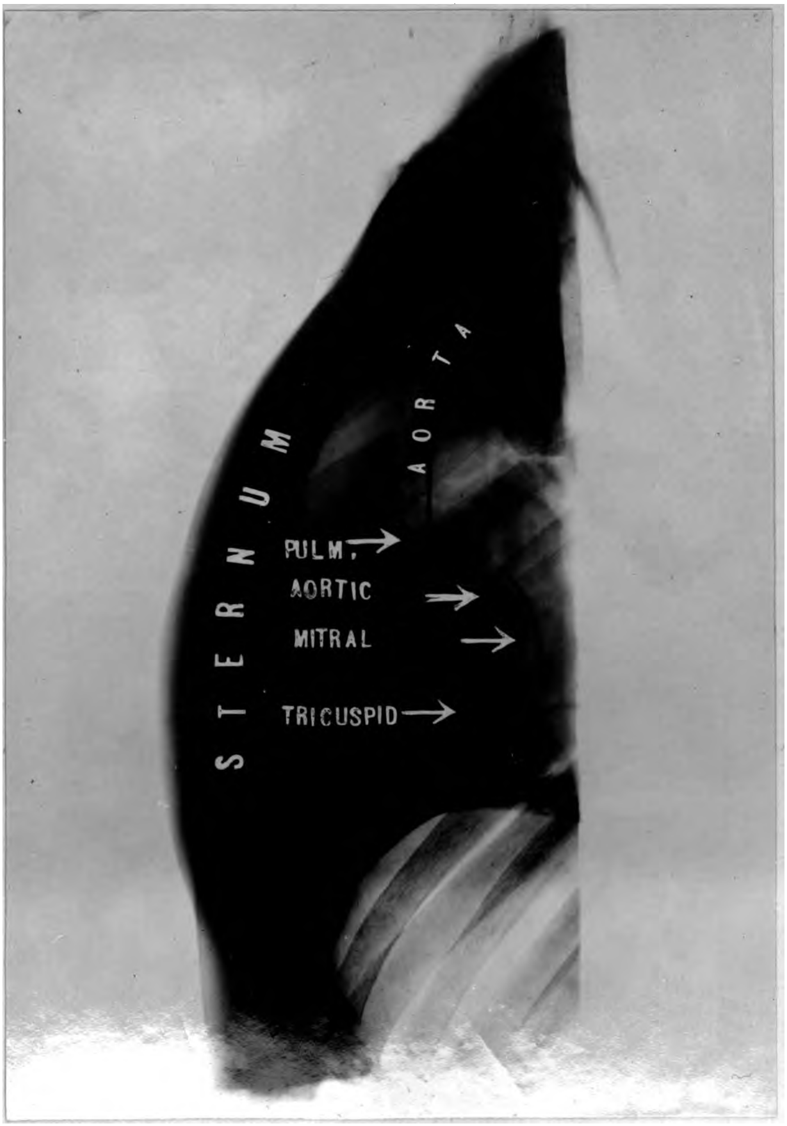
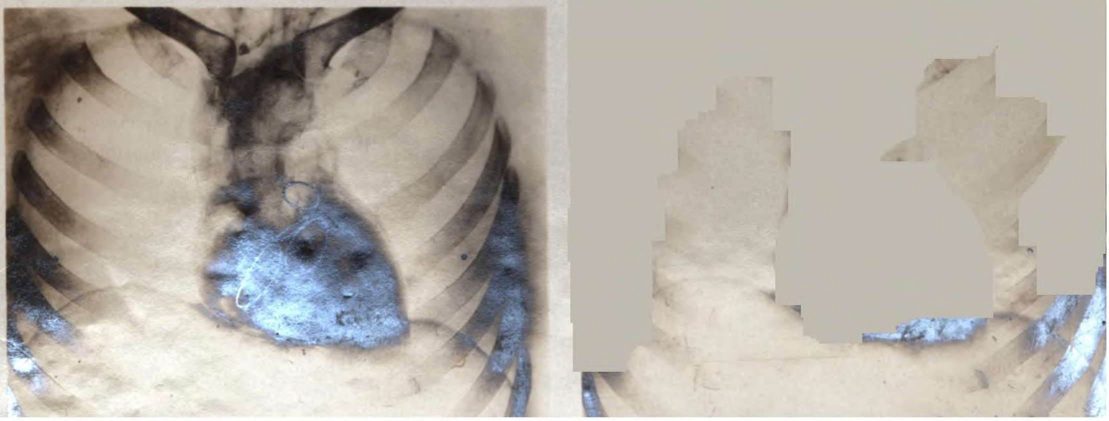


Fig. 3

¶ Although the data obtained from a single case cannot by any means be considered of universal application, the method gives such unequivocal results that it promises to be of value as a means of study.

The Anterior Thoracic Wall, With Heart in Situ

Stereo. 12. **Serial** № 405



¶ "In the Roentgenology of the heart it has long been disputed as to the exact parts which correspond to the various chambers of the heart in the outline of the Roentgen silhouette. The following notes are the results of a long course of experimental inquiry, confirmed by careful observation of the pulsation of the heart as seen with the fluorescent screen:

¶ "Our first object is to differentiate the separate cavities of the heart. In the 'Fortschritte auf dem Gebiete der Roentgenstrahlen,' Vol. XVI. I have shown that under especially favorable conditions the various cardiac cavities may be accurately differentiated. Roentgen technique is improving so rapidly that we may hope soon to be able to obtain this accurate differentiation even in normal cases. In order to read and understand the Roentgen shadow it is necessary to determine, with accuracy, what part is taken by the blood-vessels and heart in the formation of the sagittal Roentgenogram.

¶ "This matter has occupied my attention for many years, and I may here briefly allude to one only of the various methods which I have adopted, which however, is subject to one disadvantage, namely—that the heart was not Roentgenographed in situ.

¶ "The heart, after having been removed from the body, is distended with wool, so that it may assume the diastolic form. It is then hardened by one of the usual methods, after which the wool is removed, when the cavities of the heart remain distended, with the walls in their natural position. The Roentgenogram of a heart prepared in this way shows accurately the details of its external and internal architecture.

¶ "I have already referred to the disadvantage of this method, in that the organ has been radiographed after enucleation from the body. The method, however, is capable of giving us information which is obtainable in no other way, and may do good service until such time as we are enabled to use even more accurate methods."

¶ Our efforts have been directed towards overcoming the difficulty mentioned by Groedel, and also towards supplementing the data hitherto obtained by other means.

HAIR PIN FREE IN URETHRA FIFTEEN YEARS

By John Hunter Selby, M. D., Washington, D. C.

P. M. M., male, age 25 years. **Operated by Thomas Neill, M. D.**

PAST **History.**—At the age of nine (9), patient inserted a steel hairpin by its blunt end into his urethra. The entire instrument was introduced, whereupon the points sprung apart behind the meatus. All efforts to extricate it failed. The discomfort was slight, but mental anguish induced him to complain of having hurt himself astride a fence. The family doctor discovered the abnormal rigidity, but being ignorant of the prank committed, he decided that osseous tissue was present.

¶ Soon the boy became accustomed to the foreign body, which gave him very little trouble until after his marriage.

¶ **Present History.**—Recently he was awakened in the morning with irritation of the bladder, manifested by a sense of fullness, urgency and frequency. A few drops of blood appearing at the meatus decided him to consult a surgeon, to whom he confessed.

¶ **Roentgen Examination.**—The fluoroscope revealing the hair pin, we proceeded to localize it by the stereoroentgenographic method. Bismuth was dusted over the inguinal surface, the scrotum and perineum. Traction was made on a cord tied behind the glands, which held the plane of the pin parallel to the plane at the plate holder.

¶ **Roentgen Ray Findings.**—A metal hair pin two inches long, situated in the urethra, the points towards the meatus and three and one-half inches from it. There was no evidence of encrustation, rust or erosion.

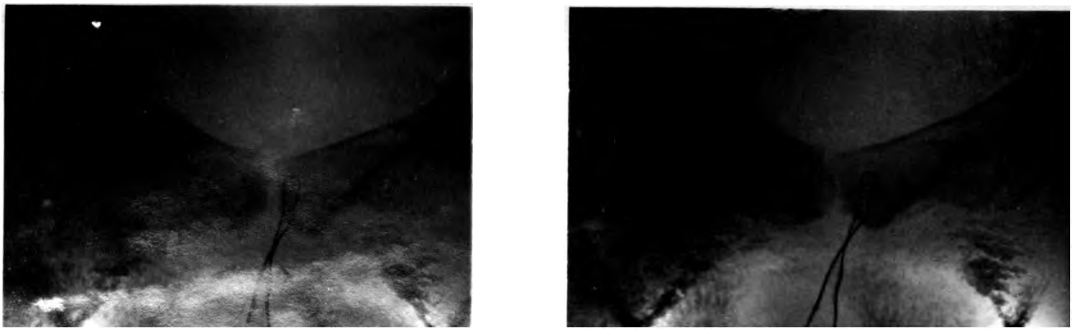
¶ The urine showed large flakes of mucus and some albumin and pus.

¶ **Operation.**—The skin and subcutaneous tissues were infiltrated with cocain 1:10000 and the deeper tissues with the same strength solution. A median incision was made one and one-half inches long in the perinum just over the bulb. The urethra was opened in front of the bulb and the pin found just at the anterior border, lying free in the urethra. It was easily removed with tissue forceps.

¶ The pin showed very little corroding, with a slight amount of encrustation. He was given urotropin gr. x t.i.d.

Hair Pin Free in Urethra

Stereo. 13. **Serial N° 405**



¶ On the eleventh day, the wound had healed and there had been a slight amount of leakage of urine. He was told to report at the office in about a week.

¶ **Note.**—When seen in the office about a week later, he was feeling fine. The dressing had been discarded and the wound was perfectly healed.

¶ **Remarks.**—The remarkable features in this case are: First—Pin remaining fifteen years in the urethra without causing distress or obstruction. Second—Freedom of the steel pin from extensive corrosion and encrustation.

ADENO-CARCINOMA OF THE SIGMOID

By Wm. H. Stewart, M. D., New York

J. R. A., male, age 42 years. Referred by Drs. Welker and Luckett

---

FAMILY History.—Mother died of pneumonia; Father died at seventy years, cause unknown.

¶ **Previous History.**—Operated on for appendicitis seven years ago.

¶ **Present History.**—Has been in fair health up to three months ago, when he commenced to experience some frequency in defecation. Occasionally some blood and mucus in the stools. During this time anorexia, rectal pain, and loss of weight developed. Numerous diagnoses were made, such as kinking of the intestine and hernia. Treatment of these conditions, however, did not relieve the patient.

¶ **Roentgen Examination.**—The patient was given three ounces of barium sulphate and one pint of kumyss; examination twenty-four hours later showed a distinct narrowing in the lumen of the intestine at about the junction of the rectum and sigmoid. The character of the shadows through this area, combined with the location, suggests a malignant growth at this point; at least it will have to be considered so until proven otherwise. These observations were all confirmed by a stereoroentgenographic examination of the lower portion of the large intestines, following a barium clysma.

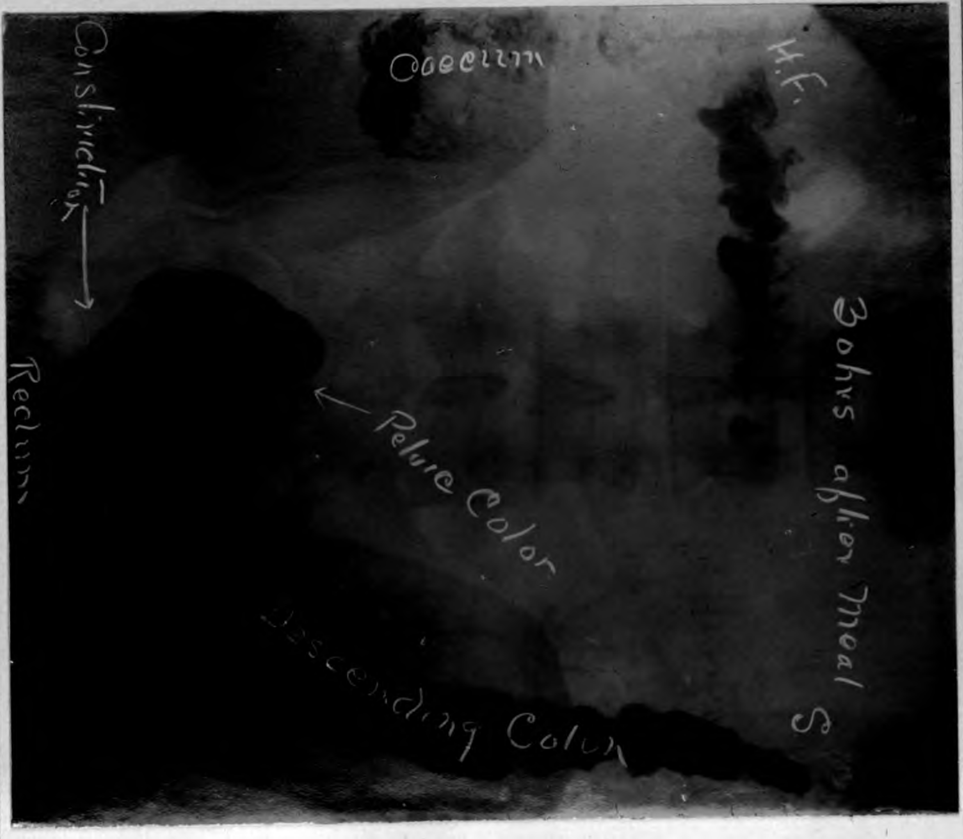


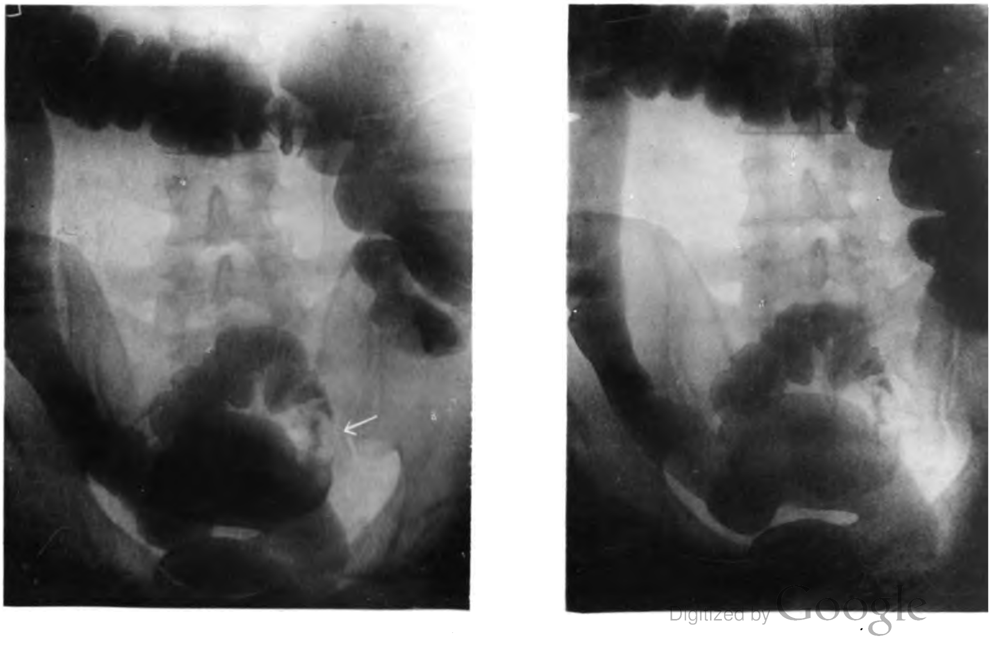
Fig. 1
Constriction in Lumen of Sigmoid, Shown after Barium Meal

¶ **Operative Findings.**—He was operated upon and a growth of considerable size found at about the junction of the sigmoid with the rectum. Four inches of the pelvic colon were removed, with an end to end anastomosis. The gross specimen showed an annular stricture, with an ulcerated irregular oval area, one and one-half inches by two inches. This ulcer had a raised edge, and its base was necrotic.

¶ **Pathological Diagnosis.**—Adeno-carcinoma.

Showing a Narrowing in the Lumen of Intestines

Stereo. 14. **Serial №. 405**



MILIARY PLEURAL TUBERCULOSIS.

By Harry Wessler, M. D., New York.

M. S., age 3½ years.

FAMILY **History.**—Father died of tuberculosis two years before.

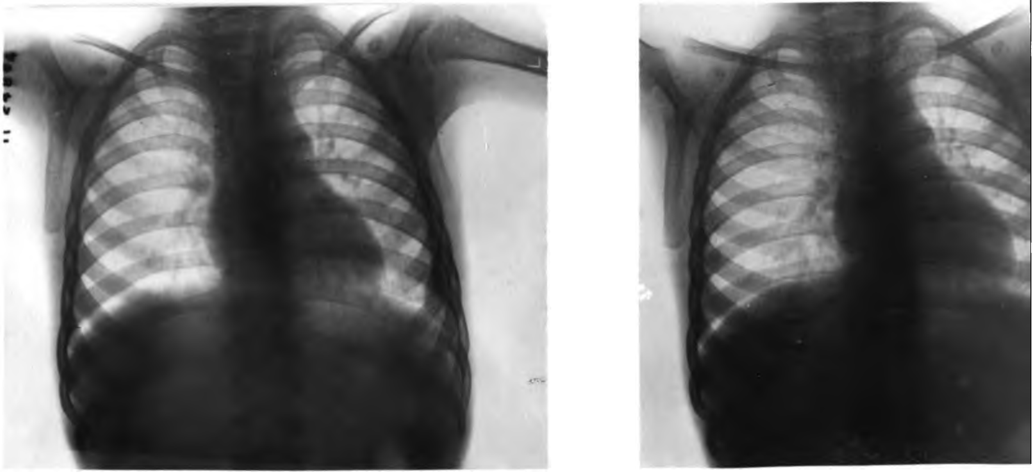
¶ **Past History.**—Scarlet fever one and one-half years ago. Otherwise no facts of importance.

¶ **Present Illness.**—Began two weeks ago with fever, vomiting and loss of appetite.

¶ Physical examination on admission: a well formed and developed child, presenting the symptoms of tuberculous meningitis well advanced. The

Showing Miliary Tubercles on the Pleura.

Stereo. 15. **Serial Nº 405**



only pulmonary physical signs were a few dry subcrepitant rales at the extreme left base in the axilla.

¶ The subsequent course of the case was irregular fever one week, with gradual increase in the signs of meningitis, resulting in death.

¶ **The Roentgen Examination.**—Made November 6, three days before death, showed a moderate enlargement of the lymph nodes on both sides. Also, in the axillary portion of the left base just above the diaphragm, there was seen a small area showing numerous infiltrations closely set together, which on stereoscopic examination appeared to lie in the pleura. The Roentgen appearance was that of a miliary pleural tuberculosis in an early stage.

¶ The lateral stereoroentgenogram of the head, a copy of which is reproduced herewith, shows several well-defined localized areas of decreased opacity of the cranial bones on the right side of the skull. One of these areas is located in the parietal bone, two in the frontal bone, and one is apparently divided between the parietal and the temporal bones. There is a distinct clouding of the right maxillary antrum, also a deformity of the upper and lower maxillae on the right side, which are pushed inward by the tumor mass. The thinning of the bone is well shown in the accompanying stereoroentgenogram.

¶ Careful neurological examination by Dr. W. H. Riley failed to reveal any neurological findings, which were attributable to the tumor, aside from the defective vision.

¶ Examination of the eye grounds by Dr. L. V. Stegman showed $^{20}/_{60}$ vision in the right eye, $^{20}/_{40}$ vision in the left eye. All the intra-ocular blood vessels showed a hyperemia. This was especially noted in the nerve heads. There was no particular difference between the two sides.

¶ In considering the plan of treatment, it was decided to avoid hot water injections, at least, for the present and to attempt the reduction of the tumor in two ways; first, by the surgical removal of the large tumor beneath the right malar bone and the smaller tumor above the right eye, and; second, by treating the remnants of the tumor and the remainder of the involved skin areas by means of the Roentgen ray, using the harder rays and heavy doses through a filter of four millimeters of aluminum, plus a thickness of sole leather.

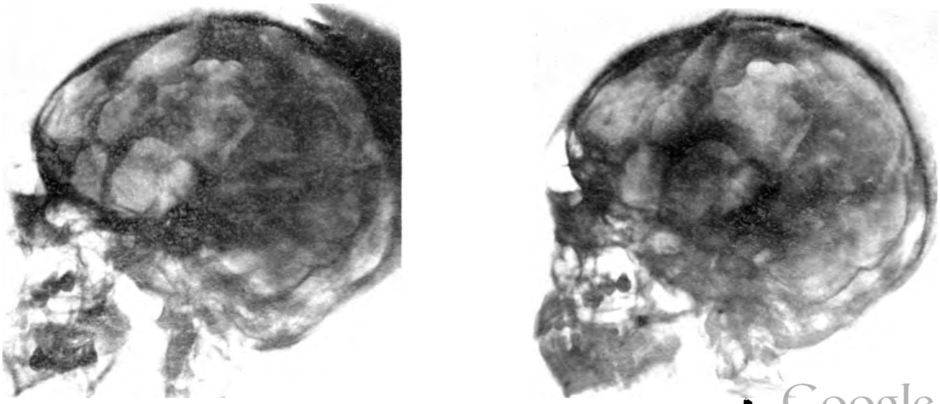
¶ Dr. R. H. Harris and the writer, therefore, operated on the patient on June 3, removing a vascular tumor the

size of a walnut from above the right eyebrow. The tumor was adherent, on its under surface, to the periosteum of the supra-orbital arch. The upper surface of the tumor seemed to be intimately associated with the skin in such a way as to make it difficult to find the dividing line between the tumor and the skin. There was also removed from beneath the right malar bone an irregular, globular mass three inches in diameter, intimately adherent to the periosteum of the upper alveolar arch and to the anterior surface of the superior maxilla.

¶ Three weeks later, the patient having completely recovered from his operation, a further reduction of the tumor was attempted by means of the Roentgen ray. The skin overlying the affected area was so divided as to afford six portals of entry for the ray. Not only the face, but also

Showing Decreased Opacity of the Cranial Bones

Stereo. 16. **Serial Nº 405**



the portion of thin skull as suggested by the roentgenogram were subjected to treatment. At first it was thought that a diminution in the facial swelling could be appreciated; but after some months of routine intensive therapy, with the hardest rays obtainable, adequately filtered, this form of therapy was abandoned as being without effect.

¶ On November 9, Dr. Harris and the writer again operated to remove as much as possible of the remaining tumor tissue. No recurrence having been observed since the last operation, we felt encouraged to do as radical a removal as possible. The result was fairly satisfactory from a cosmetic standpoint, and the patient expressed himself as well pleased.

¶ **Pathological Report.**—The tissue examined shows chiefly non-medulated nerve fibres thus demonstrating that the greater part of this tumor is a cirsoid neuroma.

GUMMA OF THE ULNA. CONGENITAL SYPHILIS.

By William H. Stewart, M. D., New York.

S. F., Chauffeur, age 23 years. **Referred by Dr. E. Pisko**

FAMILY **History.**—Both parents had lues, the father's lesion being on the face and nose, and both have been treated by Dr. Pisko. An older brother acquired syphilis about five years ago, and now has a gumma of the tongue.

¶ **Present History.**—In July, 1915, patient commenced to complain of pain in the upper part of the right forearm. This pain was continual, more severe at night and described as similar to a toothache. He noticed a small swelling on the inner side of the arm in the region of the epitrochlear gland, and there was considerable enlargement on the inner side of the right forearm in the lower third, it was hard and immovable; the skin over same was normal in appearance. This swelling gradually increased in size until he appeared for treatment in September, 1915. There was no venereal history. Wasserman 4 +

¶ **Roentgen Examination.** — Stereoroentgenographic examination reveals a marked periosteal rising, which surrounds the entire lower two-thirds of the shaft of the ulna. In the lower half on the inner side is an excavation, the crest of which corresponds to the height of the raised

periosteum; this crater extends down to the level of the shaft, within this excavation is a mass of soft, bony tissue, showing as radiating lines at right angles to the long axis of the bone; through the center of this mass is a distinct line, which is believed to be the remains of the periosteum. There is marked involvement of the soft parts. A diagnosis of a periosteal gumma was made.

¶ **Remarks.**—Under antispecific treatment he has gradually improved. Tumor is much smaller and consistency softer. Pains less, and loss of power, which manifested itself in the early appearance of the lesion, gradually diminishing.

Periosteal Rising on the Shaft of the Ulna.

Stereo. 17. **Serial №** 405

CALCIFIED FIBROMA OF THE FOREARM

By LEOPOLD JACHES, M. D., New York

H. S., male, 51 years. Patient of Dr. C. A. ELSBERG

FAMILY and Previous History.—Of no importance.

¶ **Present Illness.** — Patient first noticed a slight diffuse swelling of the left forearm, about eighteen years ago. It was painless up to eight years ago; since then there has developed pain, which is progressively becoming more intense. It is especially painful at night. Power has become much diminished, until, at present, there is very little strength left in the arm. He has had no sensory disturbances in that extremity. There have been no chills nor fever, and no loss of weight or of general body strength.

¶ The patient's previous occupation was lifting heavy blocks of wood, with forearm support.

¶ **Physical Examination.**—The left forearm shows an oval, hard, tender mass, six inches by three inches in size, on the inner side of the ulna, at its upper end. The veins over the mass are markedly distended. The skin is not attached to the mass. Moti[illegible]he elbow is free, about fifteen degrees of supination [illegible]tion is possible.

¶ **Roentgen Examinatio**[illegible] mass, which is fairly completely calcified[illegible] inches by two inches, appare[illegible] place

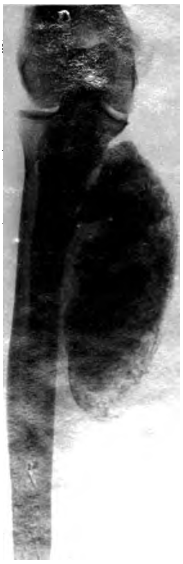
on the inner surface of the ulna, just below the coronoid, is present on the inner side of the left forearm. In appearance it is very strongly suggestive of a calcified hematoma.

¶ **Operation.**—Excision of Tumor of Left Forearm, by Dr. Elsberg.

¶ An incision was made along the inner side of the anterior surface of the left forearm. The fascia was split. The muscles were retracted by separating them along the intermuscular septa. The nerves and blood vessels were then retracted. The tumor mass was exposed and carefully enucleated. It was apparently attached to the deep fascia. It was overlying the ulna, but not attached to it. The bone was intact. The deep muscles over the ulna were divided for a short distance longitudinally. These were closed with interrupted catgut sutures. The fascia

Calcified Fibroma of the Forearm.

Stereo. 18. **Serial No 405**



was closed with chromic gut, and the skin with silk. Eight days after the operation the patient was discharged well.

¶ **Report of Pathological Examination.**—By Dr. F. S. Mandlebaum.

¶ The specimen consists of a tumor apparently composed of a mass of lime, which has been deposited in a fibrous stroma. The tumor measures 11 x 6 x 5 cm. and is covered on its surface by a thick, shiny capsule, which in places is somewhat edematous and gelatinous.

¶ The microscopical examination shows a degenerative fibromatous stroma in part adipose, with diffuse calcification.

¶ **Diagnosis.**—Calcified fibroma.

JOINT "MOUSE" IN THE KNEE JOINT, DEMONSTRATED BY ROENTGEN EXAMINATION

By LEON THEODORE LE WALD, M. D., New York

T. J., male, 36 years.

OCCUPATION, a porter, was admitted to St. Luke's Hospital, New York, on February 17, 1916.

¶ **Chief Complaint.**—Locking of right knee joint.

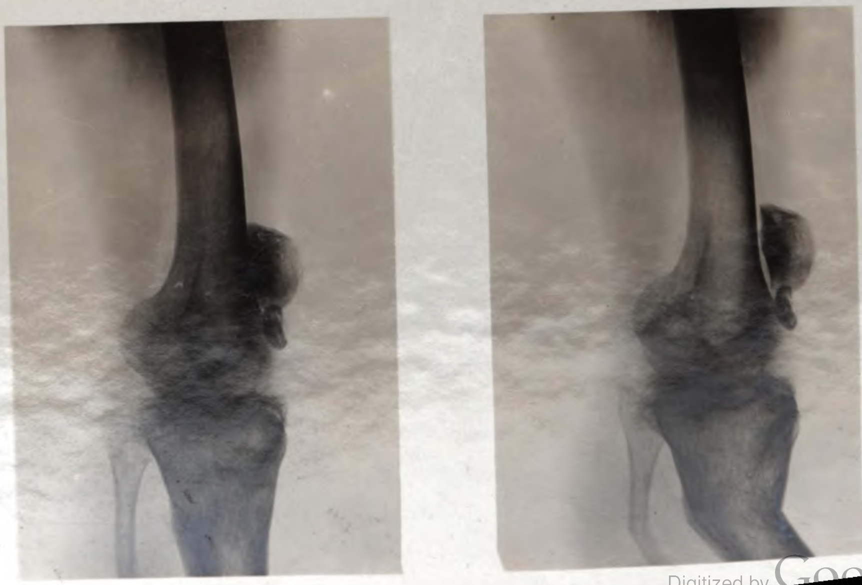
¶ **Present Illness.**—Onset August 6, 1915. Patient suddenly had applied the brake on a baggage truck and then had severe pain in right knee joint, which almost caused him to faint. He was unable to walk or bend his right knee. A plaster cast was applied for several weeks. He then went about, but now and then the knee would lock, especially if he twisted it. He has learned to manipulate the knee in such a way as to dislodge something, after which it is comfortable again. It is not followed by pain or swelling. On inquiry, he states that he had injured the knee several times, while lifting trunks, before the present trouble began. Family history negative.

¶ **Physical Examination.**—There is a swelling of the right knee joint, which bulges when the leg is extended, and disappears when the knee is flexed. A movable mass about three by two cm. can be felt above the patella. By careful manipulation the mass can be coaxed downwards

moved upwards, crossed over above the patella and pushed downwards on the **inner** side of the knee joint and again roentgenographed. A roentgenogram in a lateral projection was made of the knee with the joint "mouse" below the patella, and in such a position that its shadow is almost eclipsed by the shadow of the femur. This is rather an important observation and illustrates the necessity of roentgenographing in various directions, for had a single roentgenogram been made in this position, the body, dense as it is and so definitely outlined in other positions, might easily have been overlooked. It is not unusual to have requests sent to Roentgenologists to have only one exposure made. Of course this is absurd, for the question as to the variety of exposures and methods of examination may safely be left in the hands of the conscientious Roentgenologist.

Joint "Mouse" Below Patella.

Stereo. 21. **Serial №** **405**



¶ **Operation.**—February 21, 1916. By Dr. William A. Downes, who found lying free in the synovial cavity of the right knee a piece of tissue measuring 2.5 by 2 by .8 cm. The body shows small irregularities on its surface and is of cartilaginous or bony consistency.

¶ The incision into the joint capsule one inch in length, first to the right of the patella was closed with fine chromic gut sutures. Skin and subcutaneous tissues likewise.

¶ Patient discharged from the hospital seven days later, with the wound healed and no pain on motion of the knee joint.